options

benefits as individual as you

July 1, 2012 – June 30, 2013

2012-2013

Enrollment Guide • COBRA and Retirees

LINK

NEBRASKA Administrative Services

Revised on 05/01/2012

LINK is an ***innovative concept***
linking people, service, and business together
by providing ***easy access***
to every day applications and resources.

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STATE OF NEBRASKA 2012/2013 BENEFITS

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We are ***rolling out the red carpet*** to a brand new ***Superhero!***

LINK **features a *user-friendly design* and provides you a *quick* and *easy* way to:**

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- **review leave balances**
- **discover more information about UnitedHealthcare® and your 2012 Health Benefits**
- **access to 2012 Benefits Open Enrollment**
- **links to applications and systems**
- **and much, much more!**

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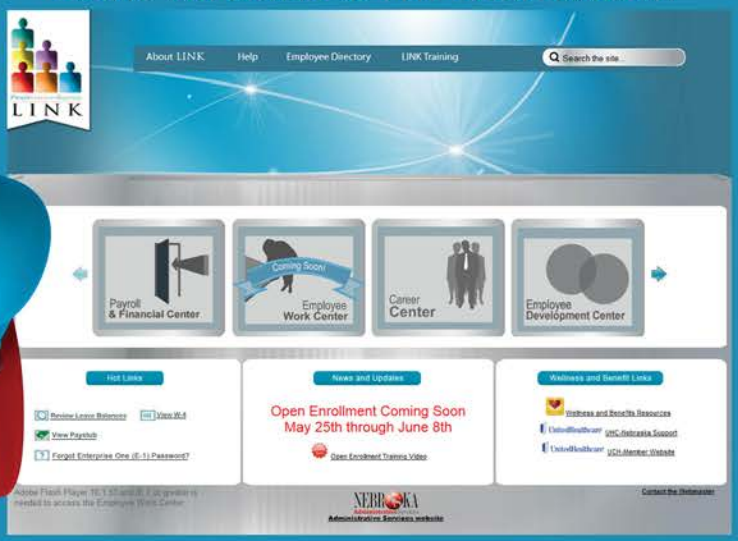

**training will be available prior to Open Enrollment*

OPEN ENROLLMENT 2012

Starring **YOU!** *and* LINK

link.ne.gov

NEBRASKA Administrative Services
State Employee Wellness & Benefits

UnitedHealthcare®

Reminders for the 2012-2013 Plan Year

- The federal government has mandated that Social Security numbers must be listed for all enrollees and their covered dependents enrolling in a group health plan
- All employees and former employees must re-enroll in health, dental, and vision plans to have coverage for the new plan year beginning July 1, 2012; current elections in these plans will end on June 30, 2012

Open Enrollment

BEGINS:
Friday, May 25, 2012 at 8:00 a.m. C.D.T.

ENDS:
Friday, June 8, 2012 at 5:00 p.m. C.D.T.

The State of Nebraska partnered with Aon Hewitt to conduct a Dependent Eligibility Verification Audit whereby employees and former employees were asked to verify the eligibility of their dependents who receive State employee health, dental and vision benefits. Effective July 1, 2012, our new medical provider, UnitedHealthcare, will partner with Aon to continue this for the State. The ongoing Dependent Eligibility Verification Process will require all employees who are new hires or rehires as well as those current employees and former employees who incur a qualifying life status change to submit documentation to Aon in order verify that all newly added dependents are eligible for coverage. The Dependent Eligibility Verification Process is necessary to ensure only eligible dependents are enrolled in our State plans.

When employees and former employees complete their enrollment, they will be asked to certify that the dependents and information given is true and complete to the best of their knowledge.

IMPORTANT CHANGES FOR 2012-2013 PLAN YEAR

ALL HEALTH PLANS:

- ✓ Will now be administered by UnitedHealthcare
- ✓ 24-hour nurse line
- ✓ One ID card will be issued for both medical services and pharmacy services

WELLNESS PLAN:

- ✓ Hospital Emergency Room is changing from a copay to 20% deductible

CHOICE PLAN:

- ✓ Office visit copay is going to $30
- ✓ Hospital Emergency Room is changing from a copay to 20% deductible
- ✓ Outpatient Rehab Services are changing from copay to 20% after deductible
- ✓ Home health care and Hospice care are changing from copay to 20% after deductible
- ✓ Allergy shots are changing from copay to 20% after deductible
- ✓ Routine vision exam plus refraction is changing from copay to 20% after deductible
- ✓ Ambulance is changing from copay to 20% after deductible
- ✓ Urgent care is changing from copay to 20% after deductible
- ✓ In-Network Plan year deductible is changing to $800/individual and $1,600/family
- ✓ Out-of-Network Plan year deductible is changing to $1,200/individual and $6,000/family
- ✓ In-Network Out-of-Pocket maximum is changing to $4,000/individual and $8,000/family
- ✓ Out-of-Network Out-of-Pocket maximum changing to $6,000/individual and $12,000/family

REGULAR PLAN:

- ✓ Hospital Emergency Room is changing from a copay to 20% deductible
- ✓ In-Network Plan year deductible is changing to $500/individual and $1,000/family
- ✓ In-Network Out-of-Pocket maximum is changing to $1,500/individual and $3,000/family
- ✓ Out-of-Network Out-of-Pocket maximum is changing to $3,500/individual and $5,500/family

HIGH DEDUCTIBLE PLAN:

- ✓ Hospital Emergency Room is changing from a copay to 20% deductible

HEATHFITNESS-WELLNESS PROGRAM:

- ✓ **NEW PROGRAM! Cardio Log –** Wellness participants expressed interest in logging a greater variety of workouts. With Cardio Log, you can track a variety of sports, fitness classes, cardiovascular, strength training and flexibility workouts
- ✓ **NEW PROGRAM! NutriSum –** As a result of participants expressing interest in additional weight management programs, we are proud to offer **NutriSum**
- ✓ The **EMPOWERED Coaching** program now includes Condition Management and Lifestyle Management services together in one coaching program
- ✓ The **Walk This Way** program criteria has increased to 700,000 steps to qualify for the Wellness Plan
- ✓ Your **Wellness Plan Checklist** now includes more wellness program participation detail in the Completed Criteria Activity tab

OPTUMRx™

- ✓ UnitedHealthcare will now be administering the pharmacy benefits
- ✓ One ID card will be issued for both medical services and pharmacy services
- ✓ Walgreens will be an in-network provider with UHC OptumRx™
- ✓ The new Specialty Pharmacy Manager will be UHC OptumRx™

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Welcome

Welcome to Open Enrollment for 2012-2013. It's been a busy year with several new developments since we last went through this process. We want to share with you all that we have been up to and are excited to roll out the red carpet on a whole new Open Enrollment experience, one we hope you will find quick and easy to use. It includes a LINK, a few clicks and UHC. Read on to see what this is all about. Come experience the excitement!

Effective July 1, 2012, UnitedHealthcare (UHC) is our new health care administrator and pharmacy benefit manager. We are pleased that we are able to keep flat the premiums for the Regular and High Deductible Plans and lower the premiums for the Wellness and Choice Plans. We know there is a lot of interest in this transition and it is the goal of the State of Nebraska and UHC to make this a seamless conversion.

While much effort has been devoted to improving your Open Enrollment experience, we have not lost sight of the important role our Wellness Program plays in helping employees make healthier lifestyle choices and become aware of risk factors. Through routine screenings we continue to detect new cases of early stage cancer conditions and diagnose high cholesterol and high blood pressure cases. In addition, over 120 participants have now quit smoking as a result of the wellness program and this past year we had our first Walk This Way participant log over 10 million steps! Others continue to notice these statistics too. We routinely receive calls from other states inquiring about how the program works and last fall it was recognized with an Innovations Award from the Council of State Governments.

It has been a busy year. We are excited to be able to offer you a quick and easy Open Enrollment process, as well as competitive premiums. As you review the Open Enrollment materials, you will notice that we have made some changes to the various health plans. It is important to remember that your benefits and coverage are determined by the State and not by any vendor. Please evaluate the plans carefully and take this opportunity to select the coverage that best fits your personal needs. You will find a side-by-side comparison of the health plans on pages 20 and 21 of this guide.

As a reminder, your new Open Enrollment experience begins on May 25, 2012 at 8:00 a.m. C.D.T and ends on June 8, 2012 at 5:00 p.m. C.D.T. The decisions you make will take effect on July 1, 2012 and will remain in effect until June 30, 2013. Our Wellness and Benefits staff is available to assist you as needed for questions on the benefit options presented in this guide. They can be reached at 402-471-4443. In addition you may access **link.ne.gov** and connect to Wellness and Benefits Resources for more information.

Sincerely,

Carlos Castillo Jr., Director
Administrative Services

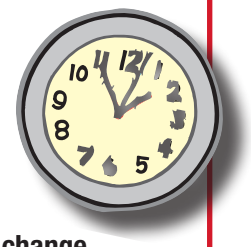
Introduction

It's time once again to consider your ***Options***, our competitive benefits program. Get started by carefully reading this Enrollment Guide and share it with your family. You'll find information about all of your benefit options, how to enroll and where to go if you have any questions.

You must re-enroll in all health, dental, and vision plans to have coverage effective July 1, 2012 through June 30, 2013. All current elections in these plans will end on June 30, 2012.

Because of governmental regulations, your Social Security number and the Social Security numbers of your covered dependents who are enrolling in a group health plan must be correct and on file.

How long do I have to make life status changes?



Any change in coverage must be made within 30 days of the change in status or you will not be able to change your coverage until the next Open Enrollment period or another qualifying status change. Documentation of the status change must be provided to Administrative Services, State Wellness and Benefits office before the change will be approved.

If you or a covered dependent experience a qualified status change that allows you to terminate your insurance coverage, you have 30 days to complete the necessary paperwork and provide the proper documentation. Coverage will terminate the first of the month following the request; no refunds or retroactive terminations will be allowed.

Making Changes During the Year

It's important that you carefully select your options during Open Enrollment. The choices you make during Open Enrollment remain in effect until June 30, 2013. You can make limited changes at other times during the year only as a result of a qualifying event as defined by the IRS. These qualifying events include:

- A marriage, divorce or legal separation
- If adding a spouse due to marriage, the effective date is ALWAYS the first of the month following the marriage
- The birth or adoption of a child
- The death of a spouse or dependent child
- Gain or loss of coverage for dependent child under age 26
- A change in employment status for you or your spouse if it affects your benefit eligibility
- A change corresponding with a spouse's open enrollment period at his or her place of employment
- Being newly eligible for Medicare Coverage
- Losing eligibility for coverage under a State Medicaid or CHIP program
- Becoming eligible for State premium assistance under Medicaid or CHIP.

If you are requesting to enroll in any of the State's insurance plans, you will only be eligible to enroll in those benefits that were terminated as a result of the qualified event.

When requesting to add/enroll in coverage due to a loss of other coverage, the effective date is the first day of the month following the loss of coverage.

Continuing Your Coverage – COBRA

As a reminder, in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when coverage under the State of Nebraska's benefit plans ends, you and/or your eligible dependents may be eligible to continue your medical, dental, vision, EAP and medical flex benefits at your own expense for a temporary period of time. To be eligible, a qualifying event causing the loss of coverage must take place. The date that event occurs determines your eligibility status. Your existing coverage is always carried to the end of the month in which the qualifying event occurs as long as the entire monthly premium has been paid.

A qualifying event may be an employee's termination, a divorce or a dependent child is no longer eligible. For a complete list of qualifying events, who may continue coverage and the maximum period of continuation, please refer to your summary plan description (SPD) or contact State Employee Wellness and Benefits at **402-471-4443** in Lincoln or at **877-721-2228** outside of Lincoln.

Continuation of All Eligible Benefits

COBRA is a federal law allowing the continuation of health / dental / vision / EAP / medical flex benefits for any employee or dependent who would otherwise lose group coverage due to a qualifying event.

Qualifying Event

A qualifying event is an event that occurs for an employee or dependent (e.g., employee terminates employment, dependent quits school, see list under Eligible Family Members). The date that event occurs determines eligibility status. Existing insurance is always carried to the end of the month in which the qualifying event occurs as long as the entire monthly premium has been paid.

Eligible Employees

If your employment with the State is terminated or your work hours are reduced below 20 hours per week, and you were covered by a State plan, you become eligible for COBRA for up to 18 months (29 months for disabled employees if not eligible for disability retirement from the State).

Eligible Family Members

Certain family members also have the option to continue all eligible benefits after the benefits would normally cease. Family members who have a qualifying event can continue the eligible benefits for up to a maximum of 18 to 36 months.

Family members are eligible for 18 months of coverage, if the following occurs:

- Employee's termination;
- Reduction in employee's hours of employment to less than 20 hours per week.

Family members (spouse or dependent children) are eligible for up to 36 months of coverage, if the following occurs:

- Death of the employee;
- Divorce involving an employee (upon completion of Nebraska's six-month waiting period for insurance benefits) or legal separation (as granted by a judge);
- Child ceases to be an eligible dependent (reaches 19th birthday and is no longer a full-time student, marries, quits school, obtains full-time employment (this does not mean full-time work through summer months or temporary jobs), or reaches 24th birthday).

Questions concerning Medicare entitlement and continued coverage for dependents should be directed to the State Employee Wellness and Benefits office at **402-471-4443** in Lincoln or at **1-877-721-2228** outside of Lincoln.

Under COBRA Law, the employee or a family member has the responsibility to inform his/her agency's HR representative of a divorce, or a child losing dependent status, under the employee's present carrier within 60 days of the date of the event. If it is beyond 60 days COBRA will not be offered.

For Retirees Only

During Open Enrollment, you may change your medical plan option (for example, Regular PPO to the Wellness PPO) or your level of coverage (for example, Family + Spouse + Dependent Children [Family Coverage] to Employee + Spouse [Two Party Coverage]). **However, you may not add dependents or coverage/plans not currently in effect.** If a dependent is dropped during Open Enrollment, the dependent can only be added at a later date with a qualified event, proper documentation and within 30 days of the qualified event. If coverage is dropped, you cannot add the coverage at a later date.

Early Retiree Program and Disability Retirement

This program was created for State employees who meet the qualifications to retire. The program allows a retiree, at his or her own expense, the option to continue medical, dental, vision and EAP coverage if he or she was actively enrolled in the benefit on their last day of employment. Coverage may be continued up to the first of the month in which the employee reaches age 65. If the employee is enrolled in the Medical Flexible Spending Account program on the last day of employment, participation may be continued only through the remainder of the current plan year.

Retirees who become entitled to Medicare part A or part B, prior to the age of 65 can stay on the Early Retiree's program until the first of the month of their 65th birthday, however they need to notify the State Employee Wellness and Benefits office of their entitlement date so coordination of benefits with the health insurance company will take place without any interruption to their medical service payments.

Eligibility of Employee

Employees who retire, including those who retire due to a disability and meet the qualifications regarding disability retirement.

If an employee is 65 years old or older at the time of Retirement they will be offered an 18-month COBRA event.

Eligibility of Family Members

If a family member reaches age 65 before the employee, the family member is ineligible to continue coverage through the retiree program. Contact the insurer for information about conversion options.

Questions concerning Medicare entitlement and continued coverage for dependents should be directed to the State Employee Wellness and Benefits office at **402-471-4443** in Lincoln or at **1-877-721-2228** outside of Lincoln.

Disability Retirement

An employee under age 55 may retire as a result of a disability. You will need to contact the Nebraska Public Employees Retirement System on how to apply for this. An employee who chooses this option must first elect COBRA and once he/she is approved, the Retirement System will notify the Administrative Services State Employee Wellness and Benefits office. The individual's coverage will be converted to the Early Retiree Health Plan until the first of the month he/she reaches age 65.

Choosing Your Health Coverage

Important Changes For 2012-2013 Plan Year

Beginning July 1, 2012 UnitedHealthcare is pleased to begin serving State of Nebraska employees and dependents as your health care administrator and pharmacy benefit manager.

Your medical plans give you the freedom to see any doctor or hospital in the UnitedHealthcare nationwide network, including specialists, without a referral.

Updated Plan Names	
Old Plan name until July 1, 2012	New Plan name beginning July 1, 2012
Wellness PPO	Wellness Plan
Blue Choice	Choice Plan
Regular PPO	Regular Plan
High Deductible PPO	High Deductible Plan

Questions?

Visit link.ne.gov and connect to Wellness and Benefit Resources or call UnitedHealthcare Customer Care at 1-877-263-0911.

Your transition to UnitedHealthcare

- **Who is UnitedHealthcare?**
  UnitedHealthcare is a health insurance company, serving more than 38 million people. The UnitedHealthcare statewide network includes 3,000 physicians and health care professionals, as well as over 85 hospitals and growing. The nationwide network consists of more than 676,000 physicians and health care professionals and 5,190 hospitals. UnitedHealthcare is one of the businesses of UnitedHealth Group (NYSE: UNH), a diversified Fortune 500 health and well-being company.
- **Does UnitedHealthcare provide coverage or administrative services to other employers in the State of Nebraska?**
  Yes, it does. UnitedHealthcare provides health care coverage for some of the largest employers in Nebraska. In fact, over 250,000 Nebraskans carry the UnitedHealthcare health plan ID card.
- **When will you get a UnitedHealthcare health plan ID card?**
  You will receive a new health plan ID card by July 1, 2012. Your new health plan ID card can be used both at your doctor's office and your pharmacy. The dependents that you elect to cover during Open Enrollment will also be listed on your new health plan ID card.
- **Call 1-877-263-0911 for assistance with obtaining a temporary card.**

Your Health Coverage

You have four great plans to choose from. All four health plan options are provided through UnitedHealthcare and offer both in-network and out-of-network coverage.

Visit **link.ne.gov** and connect to Wellness and Benefits Resources to learn more about your 2012/2013 benefits administered by UnitedHealthcare.

- Wellness Plan (formerly known as Wellness PPO)
- Choice Plan (formerly known as BlueChoice)
- Regular Plan (formerly known as Regular PPO)
- High Deductible Plan (formerly known as High Deductible PPO)

Take a look at the chart below to see each plan's features.

What you might consider when choosing a health plan:	Wellness Plan	Choice Plan	Regular Plan	High Deductible Plan
Will I have access to the state and national network?	Yes	Yes	Yes	Yes
Do I need a referral for a specialist?	No	No	No	No
Can I access online services, tools and programs?	Yes	Yes	Yes	Yes

Term to Know

ELIGIBLE DEPENDENT — Eligible dependents include your:

- **Legal spouse**
- **Children up to age 26**
- **Children over age 26 who are mentally or physically disabled and dependent upon you for support**
- **Step children can be covered if enrolled in Family Coverage only**
- **An employee may claim a grandchild as an eligible dependent for state health benefit purposes, if and only if, the employee has legal custody, legal guardianship or court ordered custody of the grandchild**

Find a Doctor or Hospital

UnitedHealthcare has more than 3,000 physicians and health care professionals, as well as over 85 hospitals in Nebraska and growing. They also have one of the largest networks in the country with more than 676,000 physicians and health care professionals and 5,190 hospitals.

Their network continues to grow as they add new physicians to their network every day. UnitedHealthcare is continuously inviting additional providers to join their network.

To get started on finding the right doctor for you

- Visit **link.ne.gov**
- Connect to Wellness and Benefits Resources
- Click on "Find a Doctor/Hospital"
- Choose "Find a physician/facility near you"

Why use a network provider?

All of our health plan offerings provide benefits for both in-network and out-of-network providers. Although you can choose to visit the provider of your choice at any time, you'll generally receive a higher level of benefit when you choose providers who are part of the plan network. Network providers have agreed to provide their services at negotiated, discounted rates, which saves you and the State money. Provider directories are located at link.ne.gov and connect to Wellness and Benefits Resources.

Important

To ensure you receive the great preventive Wellness coverage, make sure your doctor's office codes them correctly as 'routine.'

What can you do if your doctor is not in the UnitedHealthcare network?

If your physician is not in the UnitedHealthcare network, we encourage you to invite your doctor to consider joining the UnitedHealthcare network. For more details, visit **link.ne.gov** and connect to Wellness and Benefits Resources.

If your doctor is not in the UnitedHealthcare network and decides not to join the network, you may want to switch to a network provider; otherwise, services you receive from your non-network doctor will be paid at the non-network level, and your costs for the services will be higher than if you received services from a network provider.

Get trusted information when you need it

The **myNurseLine**SM program connects you to registered nurses anytime — at no extra cost to you. Just call 1-877-543-4295 after July 1, 2012. The nurses and master's-level specialists can provide information on:

- Symptoms and treatment options
- Doctors and hospitals
- Health condition management and more

Term to Know

PROVIDER:

A person or organization that system delivers professional health care. A p can be a primary care physician, spe dentist, hospital, out-patient facility, health facility, nursing home, etc.

Your Online Resources

Personalized Online Support

You have continuous access to your health and benefits information at **link.ne.gov** and connect to Wellness and Benefits Resources.

From one site, you can access benefit information, learn about available tools, resources and programs, view open enrollment materials and more. It's loaded with details on your benefit plan and much more. Once you log in at **link.ne.gov** and connect to Wellness and Benefits Resources you can:

- View and compare benefit plan options
- Search for physicians and facilities
- Find a network doctor in your area - Search by facility or physician
- Find answers to frequently asked questions
- Learn about your pharmacy benefit
- Learn about your plan details
- Track claims
- Organize health information
- Track doctor visits, immunizations, diagnoses, prescriptions and refill schedules with the Personal Health Record
- Find a pharmacy in your area

UHC.TV℠

UHC.TV is a new online television network. It presents educational and entertaining programs about good health and living well. Get inspired to take healthy steps.

Health Care Lane® – Get the word on the street

Meet a lot of friendly people who will help you make sense of health coverage and get the most from your plan. And don't forget to check out Wellness Days, a fun-filled festival of good health and wellness. You will be entertained and educated on the benefits of having a plan administered by UnitedHealthcare.

Source4Women

This online community helps you manage your own health and the health of your family.

Healthy Mind Healthy Body® e-newsletter

Select topics that are of interest to you, and UnitedHealthcare will send the newsletter monthly to your personal email account.

Storytellers

Health care success stories by the people who lived them. Many UnitedHealthcare members have shared their success stories. Hear how UnitedHealthcare helped these members, in their own words.

Mobile Tools

You might be surprised at how much can be done with just a few simple keystrokes. UnitedHealthcare strives to make it easy to get help, wherever you are.

DocGPS®

Find a doctor or hospital wherever you are with DocGPS:

- Search for network doctors, clinics and hospitals
- Get directions and more
- Compatible with select BlackBerry®, Android™ and iPhone® devices

UnitedHealthcare Health4Me℠

Once you are a member, the Health4Me app provides you with instant access to critical health information from your mobile device. The confidential app features include:

- Single-registration — you can register at **link.ne.gov** and connect to Wellness and Benefits Resources to enable both the mobile and online app functionality
- Search for physicians or facilities
- View claims, account balances, benefit plan details and your health plan ID card
- Have an Easy Connect representative contact you to answer any questions and connect you with an experienced registered nurse 24/7

Access the above resources and tools by going to link.ne.gov and connect to Wellness and Benefits Resources.

Your Pharmacy Benefit

Your State of Nebraska pharmacy benefit offers flexibility and choice in finding the right medication for you. UnitedHealthcare is your new medical insurance provider and your new pharmacy benefit manager is OptumRx™. OptumRx™ is an affiliate of UnitedHealth Group. Our State of Nebraska pharmacy benefit administered by UnitedHealthcare offers flexibility and choice in finding the right medication for you.

What is a covered drug?

A covered drug is a prescription medication or product covered under your benefit. Your Top 500 Medications Prescription Drug List (PDL) is a good resource to review medication coverage. Since the PDL may change periodically, we encourage you to log on to your member website at **link.ne.gov** and connect to Wellness and Benefits Resources and click on Pharmacies and Prescriptions for more current information.

What is a Prescription Drug List (PDL)?

The PDL includes brand and generic prescription medications approved by the U.S. Food and Drug Administration (FDA). Medications are placed on different "tiers" based on their overall value. Tier 1 is the lowest-cost tier option. When selecting a medication, you and your doctor should consult the PDL.

- Tier 1 (formerly called Generic) - Your lowest-cost option
- Tier 2 (formerly called Preferred Brands) - Your midrange-cost option
- Tier 3 (formerly called Non-Preferred Brands) - Your highest-cost option

Choose a network pharmacy

To get the most from your pharmacy benefit, you should fill your prescriptions at either OptumRx™ Mail Service Pharmacy or one of the 64,000 retail pharmacies in the UnitedHealthcare network. Filling prescriptions at pharmacies outside the network will increase your cost and may not always be covered.

To search for a network pharmacy, visit **link.ne.gov** and connect to Wellness and Benefits Resources, click on "Pharmacy Benefits" and start your search by clicking on "Click here to find a retail network pharmacy."

What do you do if you pharmacy is not in the network?

Your pharmacy plan offers an extensive nationwide retail pharmacy network; however, if your pharmacy is not in the retail pharmacy network, you can advise your non-network pharmacy to call 1-800-797-9798 for information regarding joining our pharmacy network.

Is Walgreens in the pharmacy network?

Yes, it is. Starting July 1, 2012, State of Nebraska employees will be able to have their prescriptions filled at Walgreens and pay in-network rates.

Can you use the same local pharmacy?

Your pharmacy plan offers access to 64,000 retail network pharmacies nationwide. Present your new UnitedHealthcare health plan ID card to the pharmacy before filling or refilling a prescription.

For medications you take on a regular basis, you can fill a 180-day supply through the OptumRx™ Mail Service Pharmacy. Mail order offers the convenience of home delivery and standard shipping at no additional cost to you. Plus, you'll have lower copayments and refills to manage.

What medication limitations should you be aware of?

There are different types of medication limitations. These limitations help ensure medication safety and accuracy, as well as control overall health care costs. To look up a specific limitation of a medication, please visit **link.ne.gov** and connect to Wellness and Benefits Resources once you are a UnitedHealthcare member.

- **Quantity limits**: Some medications have restrictions on the amount of medication you can receive per copayment or in a period of time.
- **Notification (Prior Authorization):** Some medications require your pharmacy to confirm coverage before your prescription can be filled. If your doctor believes you should take a medication requiring notification, he or she can request this through our Authorization Department.
- **Step therapy:** Some medications require you to try a different drug first before your requested drug is covered.

OptumRx™ Specialty and Mail Order Pharmacy

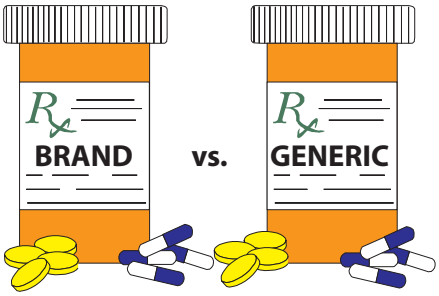
Using a specialty or mail order pharmacy are beneficial because they have experience in storing, handling, and distributing these unique medications. Specialty pharmacies also typically provide a higher level of customized care for specialty medications than traditional retail pharmacies. Specialty pharmacists and nurses have additional clinical expertise surrounding these medications and complex diseases.

UnitedHealthcare's network specialty pharmacy, OptumRx™, is your connection to quality, convenient specialty pharmaceuticals. OptumRx™ provides exceptional services for you including:

- Efficient prescription dispensing and timely delivery
- Pharmacists and licensed health care professionals available 24 hours a day to answer your questions about medications or your specific health condition
- Patient education and support services with care plan development and monitoring, if needed
- Shipping to any location in the United States for no additional charge
- Prescription shipments mailed in confidential, temperature-sensitive packaging
- Refill reminders and overall adherence monitoring
- Coaching on our Prescription Drug List including available lower cost alternatives

For questions about using OptumRx™ Specialty Pharmacy, please call the customer care number on the back of your UnitedHealthcare health plan ID card.

What is the difference between brand name and generic medications?



Generic medications contain the same active ingredients as brand name medications, but they often cost less. Generic medications become available after the patent on the brand name medication expires. At that time, other companies are permitted to manufacture an FDA-approved, chemically equivalent medication. Many companies that make brand name medications also produce and market generic medications.

The next time your doctor gives you a prescription for a brand name medication, ask if a generic equivalent is available and if it might be appropriate for you since generic medications are typically your lowest-cost option.

How can you get the most from you pharmacy benefit?

You can talk to your doctor about the following to help you get the most from your pharmacy benefit:

- **Mail order** – it eliminates monthly trips to the pharmacy and may save you money
- **Generic medications** – generic medications are approved by the Food and Drug Administration (FDA) as having the same high quality and strength as brand-name medications, but are normally less costly

Work with your doctor to see if generics or lower-tiered medications will work for you. Never change medications unless your doctor prescribes the medication.

Filling prescriptions through mail order

OptumRx™ Mail Service Pharmacy makes it easy to save money and time by delivering the maintenance medications you take every day directly to your door. You will receive a 180-day supply of your maintenance medications, many times for lower copayments than at other network pharmacies. There is no charge to you for shipping.

Mail order eliminates frequent trips to the pharmacy for your maintenance medication refills. In addition, there are licensed pharmacists that check your order to see if it is entered and filled correctly. They're available to speak to you directly should you have a question or concern about any prescribed medication.

Will you be required to use mail order for a 180-day supply of medication?

Yes, you will be. However, a 30-day supply of maintenance medication may be filled at a retail pharmacy, but the copay will be higher.

To start using mail order:

1. **Call 1-800-562-6223, 24 hours a day, seven days a week and OptumRx™ will work directly with your doctor to set up your mail order. Just have your prescription label available when you call.**
2. **Or download an order form from by going to link.ne.gov and connect to Wellness and Benefits Resources and click on "Pharmacies and Prescriptions."**

Your Prescription Drug Benefits

Wellness Plan	Tier I (Generic)	Tier II (Preferred Medications) (Formulary)	Tier III (Non-Preferred Medications) (Non-Formulary)
Retail 30-day supply	$5 copay	$25 copay	$40 copay
Home Delivery 180-day supply	$20 copay	$100 copay	$150 copay
Diabetic, hypertension and high cholesterol prescriptions			
Retail 30-day supply	No copay	$15 copay	$30 copay
Home Delivery 180-day supply	No copay	$75 copay	$120 copay

Diabetic supplies covered under the prescription drug benefit include syringes, needles, insulin pump supplies, swabs, lancets, blood monitor kits, test strips, blood glucose calibration solutions, urine tests, and blood test strips. Insulin pumps are covered under the health benefit as Durable Medical Equipment.

Wellness plan participants are eligible, with prior approval, to receive one (1) course of tobacco cessation prescription drugs for up to 12 weeks, within a rolling 12 month period, at no cost. There is a lifetime limit of three (3) courses of treatment.

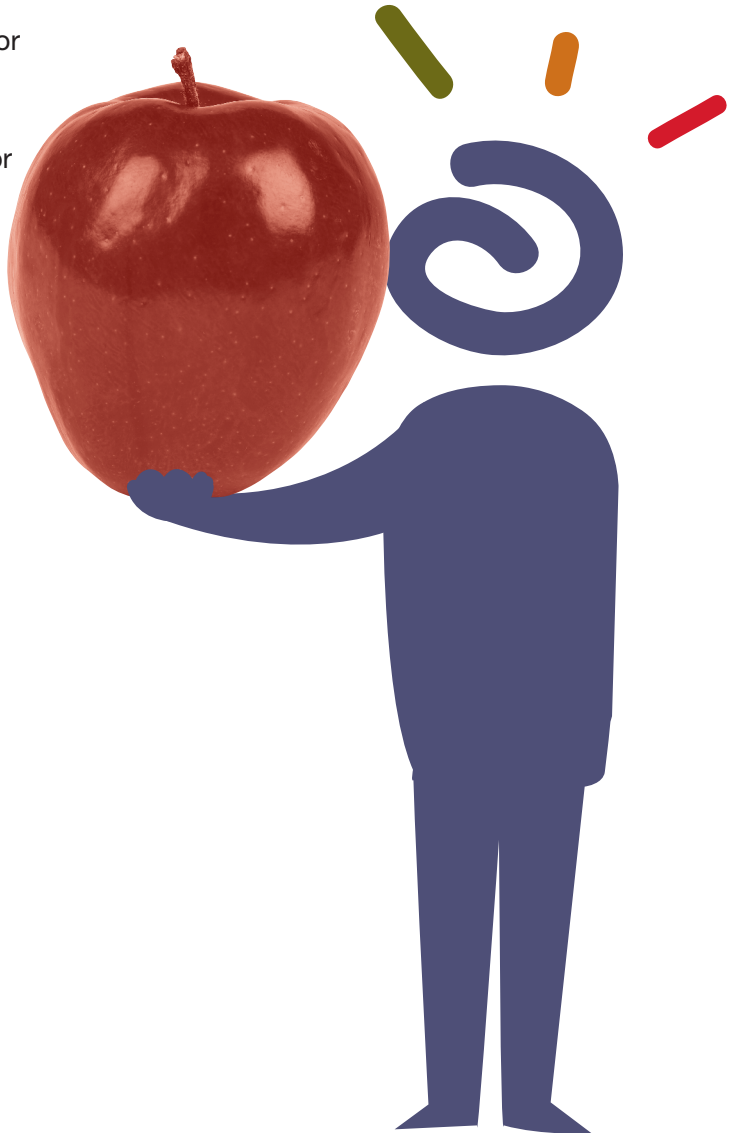
Choice Plan Regular Plan High Deductible Plan	Tier I (Generic)	Tier II (Preferred Medications) (Formulary)	Tier III (Non-Preferred Medications) (Non-Formulary)
Retail 30-day supply	$10 copay	$25 copay	$40 copay
Home Delivery 180-day supply	$35 copay	$100 copay	$150 copay

Wellness Plan Design Offerings

Living a healthy lifestyle is certainly a key ingredient to living a healthy, long life. But it is not a guarantee that you will ever be 'exempt' from a serious condition or illness. As a result, it is important to get regular checkups and screenings as recommended by your healthcare provider. The Wellness Plan offers low premiums and high quality coverage related to prevention and early detection, including 100% coverage for a wide range of age and gender based screenings.

Wellness Plan

- All blood work (including preventive) is covered up to $500
- No age restrictions for preventive screenings
- Thyroid testing
- Bone density testing (age restriction was removed)
- Routine and follow-up mammograms covered at 100%
- Routine and follow-up colonoscopies covered at 100%
- Cholesterol medications at a reduced copay or no cost for generics
- Hypertension (high blood pressure) medications at a reduced copay or no cost for generics
- Hemoglobin A1C testing twice per year
- Adult and child immunizations
- Flu shots at no cost (on-site flu shots where available)
- Maternity services
- Well baby exams
- Routine pap smear
- Routine prostate cancer screening
- Diabetes vision screening
- Diabetic prescriptions at a reduced copay
- With enrollment in the EMPOWERED Health Coaching program, Wellness plan participants are eligible with prior approval, to receive (1) course of tobacco cessation prescription drugs for up to 12 weeks, within a rolling 12 month period, at no cost. There is a lifetime limit of three (3) courses of treatment



Health Care Premiums – July 1, 2012 – June 30, 2013

Health Care Premiums for COBRA / Retiree Employee Only (Single Coverage) – Monthly			
		COBRA	Retiree
UnitedHealthcare	Wellness Plan	$420.81	$412.56
	Choice Plan	$633.95	$621.52
	Regular Plan	$509.22	$499.24
	High Deductible Plan	$305.55	$299.56
Ameritas Dental	Basic Option	$21.58	$21.58
	Premium Option	$24.15	$24.15
EyeMed	Basic Option	$5.26	$5.26
	Premium Option	$8.14	$8.14
Employee Assistance Program		$1.28	$1.28

Health Care Premiums for COBRA / Retiree Employee + Spouse (Two Party Coverage) – Monthly			
		COBRA	Retiree
UnitedHealthcare	Wellness Plan	$1,116.84	$1,094.94
	Choice Plan	$1,682.51	$1,649.52
	Regular Plan	$1,351.52	$1,325.02
	High Deductible Plan	$810.92	$795.02
Ameritas Dental	Basic Option	$43.21	$43.21
	Premium Option	$48.35	$48.35
EyeMed	Basic Option	$8.45	$8.45
	Premium Option	$13.04	$13.04
Employee Assistance Program		$1.28	$1.28

Health Care Premiums for COBRA / Retiree Employee + Dependent Children (Four Party Coverage) – Monthly			
		COBRA	Retiree
UnitedHealthcare	Wellness Plan	$864.37	$847.42
	Choice Plan	$1,302.11	$1,276.58
	Regular Plan	$1,045.97	$1,025.46
	High Deductible Plan	$627.59	$615.28
Ameritas Dental	Basic Option	$62.26	$62.26
	Premium Option	$69.69	$69.69
EyeMed	Basic Option	$8.61	$8.61
	Premium Option	$13.30	$13.30
Employee Assistance Program		$1.28	$1.28

Health Care Premiums for COBRA/Retiree Employee + Spouse + Dependent Children (Family Coverage) – Monthly			
		COBRA	Retiree
UnitedHealthcare	Wellness Plan	$1,493.77	$1,464.48
	Choice Plan	$2,250.32	$2,206.20
	Regular Plan	$1,807.64	$1,772.20
	High Deductible Plan	$1,084.59	$1,063.32
Ameritas Dental	Basic Option	$67.65	$67.65
	Premium Option	$75.72	$75.72
EyeMed	Basic Option	$13.85	$13.85
	Premium Option	$21.42	$21.42
Employee Assistance Program		$1.28	$1.28

Controlling healthcare costs requires a partnership and ownership of personal health.

	Wellness Plan		Choice Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan/lifetime maximum	Unlimited		Unlimited	
Plan Year deductible (must be satisfied before benefits are paid)	$400/individual $800/family max	$600/individual $1,200/family max	$800/individual $1,600/family max	$1,200/individual $2,400 family max
Out-of-pocket maximum (not including deductible, if applicable)	$1,400/individual $2,800/family	$3,400/individual $5,200 family	$4,000/individual $8,000 family	$6,000/individual $12,000 family
PHYSICIAN OFFICE VISITS				
Office visit/specialist/consultation/ initial Maternity Visit	$20 copay	30% after deductible	$30 copay	40% after deductible
Allergy testing / serum	No copay			
Allergy shots	No copay		20% after deductible	
Maternity Services (beyond initial visit)	No copay		No copay	
Pathology Services	Paid at 100% up to $500. After $500, 20% deductible		20% after deductible	
Surgery, Radiology & Pathology (office)	20% after deductible			
Chemotherapy/Radiation Therapy			$25 copay	
Routine Vision Exam plus Refraction	$20 copay	Not covered	20% after deductible	Not covered
PREVENTIVE EXAMS				
Flu Shots	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. There are no age restrictions on preventive screenings.	Covered at 30% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered.	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered.	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered.
Annual exam (includes foot exams for diabetics)				
Child immunizations				
Adult immunizations				
Pneumococcal Immunizations				
Well baby exams				
Diabetes vision screening				
Mammogram				
Pap smear				
Colonoscopy				
Prostate cancer screening	No copay	30% after deductible	20% after deductible	40% after deductible
EMERGENCY CARE				
Ambulance	No copay	30%; deductible waived	20% after deductible	40% after deductible
Urgent care center	$25 copay	30% after deductible	20% after deductible	
Hospital emergency room	20% after deductible		20% after deductible	
HOSPITAL SERVICES				
Inpatient hospital	20%[1] after deductible	30%[1] after deductible	20%[1] after deductible	40%[1] after deductible
Ambulatory Surgical Center	20% after deductible	30% after deductible	20% after deductible	40% after deductible
Approved skilled nursing facility				
Outpatient hospital services (diagnostic lab., radiology)				
Durable medical equipment				
Home health care, Hospice care			20% after deductible	40% after deductible
Outpatient rehabilitation services (includes OT, PT, ST and chiropractic)	$20 copay (maximum 60 sessions/ plan yr)	30% after deductible (maximum 60 sessions/plan yr)	20% after deductible (maximum 60 sessions/plan yr)	40% after deductible (maximum 60 sessions/plan yr)
BEHAVIORAL HEALTH SERVICES				
Inpatient mental health and substance abuse treatment	20% after deductible	30% after deductible	20% after deductible	40% after deductible
Outpatient mental health and substance abuse treatment	20% after deductible	30% after deductible	20% after deductible	40% after deductible

1. *Insurance carrier must be notified within 24 hours of all inpatient hospital admissions. Please see SPD for details.*

Regular Plan		High Deductible Plan	
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Unlimited		Unlimited	
$500/individual $1,000/family max	$750/individual $1,500/family max	$1,000/individual $2,000/family max	$2,000/individual $4,000/family max
$1,500/individual $3,000/family max	$3,500/individual $5,500/family max	$2,000/individual $4,000/family max	$4,000/individual $8,000/family max
$20 copay	30% after deductible	$25 copay	40% after deductible
20% after deductible		30% after deductible	
Covered at 100% for children under age 5 only		Covered at 100% for children under age 5 only	
Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered.	Covered at 30% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered.	Covered at 100% per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered.	Covered at 40% after deductible per Patient Protection and Affordable Care Act (PPACA) guidelines. If services are outside the National Health Care Reform guidelines, they are not covered.
Not covered		Not covered	
20%; deductible waived	30%; deductible waived	30%; deductible waived	40%; deductible waived
20% after deductible	30% after deductible	30% after deductible	40% after deductible
20% after deductible		20% after deductible	
20%[1] after deductible	30%[1] after deductible	30%[1] after deductible	40%[1] after deductible
20% after deductible	30% after deductible	30% after deductible	40% after deductible
20% after deductible (maximum 60 sessions/plan yr)	30% after deductible (maximum 60 sessions/plan yr)	30% after deductible (maximum 60 sessions/plan yr)	40% after deductible (maximum 60 sessions/plan yr)
20% after deductible	30% after deductible	30% after deductible	40% after deductible
20% after deductible	30% after deductible	30% after deductible	40% after deductible

Important Information: This document provides a general summary of basic benefit plan provisions and is not a substitute for the official certificates of coverage. This is not a contract. If there are any inconsistencies between this summary and the official certificates of coverage, the certificates of coverage will prevail. Please refer to the certificate of coverage for exact benefits, exclusions and limitations.

You Should Know . . .

- **Women's Health and Cancer Rights Act of 1998 —** Your State sponsored health coverage provides benefits for mastectomy-related services and complications resulting from a mastectomy (including lymphedemas). These benefits include reconstruction and surgery to achieve breast symmetry and prostheses. Normal copays, deductibles and coinsurance may apply.

- **Legal Divorce —** If you cover your spouse and/or dependent children on your State health insurance, you must notify your agency Human Resource office within 30 days of your divorce becoming final. Your divorce is considered final ***six months after*** the decree is rendered. Changes to your coverage will be effective on the first day of the month following the six month waiting period.

  If your divorce decree requires you to provide coverage for your dependent children, the children may continue coverage if they are currently enrolled in the plan. If the children are not currently enrolled for coverage, you must submit a copy of the divorce decree along with a new enrollment form adding the eligible children.

  If you have never had coverage with the State, you may apply for coverage within 30 days after the divorce is final. You must submit the divorce decree along with your enrollment form and a certificate of creditable coverage. Your ex-spouse is not eligible for coverage under the State's plan once the divorce is final, however, he or she is eligible to continue coverage under COBRA if he or she was covered immediately prior to the divorce becoming final.

  For more information, contact your agency Human Resource office.

- **LB551 – Dependents up to Age 30 –** Effective January 1, 2011, an employee may elect to continue coverage to age 30 for a dependent child who would otherwise lose coverage when he/she ceases to meet the health plan's student criteria or attains an age which exceeds the plan's limiting age, provided that the following criteria are met:

  - The child remains financially dependent upon the employee; and
  - The child was covered as an Eligible Dependent at the time coverage would have terminated.

  In order to elect **continuation coverage** for a child under age 30 the dependent must currently be covered under the plan and lose coverage due to the eligibility criteria (see page 11) and the employee must:

  - Complete and return the enrollment form to their agency Human Resource office. The enrollment form is available at their agency Human Resource office.

  The premium for continuation coverage will be equal to the plan's full, unsubsidized single adult premium. The employee will be responsible for paying the full premium each month through payroll deduction and are pre-tax.

  The coverage will terminate if:

  - The employee requests the termination because they no longer meet the criteria
  - The employee's coverage with UnitedHealthcare terminates
  - The covered dependent:
    - Marries
    - Is no longer a resident of Nebraska
    - Receives coverage under another health benefit plan or self-funded employee benefit plan
    - Attains age 30

  Continuation coverage will terminate at the end of the month in which any event listed above occurs. Coverage cannot be reinstated once it has been terminated.

- **Mental Health Parity Act —** The Mental Health Parity and Addiction Equity Act of 2008 prohibits separate treatment limits for mental illness and substance abuse. It requires equivalent cost sharing and out-of-pocket expenses for these benefits. Coverage must have the financial requirements as any other illness including: deductibles and coinsurance.

  Services must still be provided by a qualified physician or licensed psychologist, licensed special psychologist, licensed clinical social worker, licensed mental health practitioner or auxiliary providers supervised by a qualified physician.

  Benefits for ALL inpatient admissions must be pre-certified.

  Please refer to your Summary Plan Description booklet and Schedule of Benefits for exact benefit language.

- **Changes to HIPAA Special Enrollment Provisions under the Children's Health Insurance Program Reauthorization Act —** Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), group health plans and group health insurance issuers must offer new special enrollment opportunities. Effective April 1, 2009, plans and issuers must permit employees and dependents who are eligible for, but not enrolled in, a group health plan to enroll in the plan upon:

  - Losing eligibility for coverage under a State Medicaid or CHIP program, or
  - Becoming eligible for State premium assistance under Medicaid or CHIP.

  The employee or dependent must request coverage within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of being determined to be eligible for premium assistance.

  There are also new notice and disclosure requirements associated with CHIPRA.

  - Employers must notify all employees of their potential eligibility for the subsidies under Medicaid or CHIP. Employers are not required to provide these notices until the first plan year after the model notices are issued (January 1, 2012 for calendar year plans).
  - In order for States to evaluate an employment-based plan to determine whether premium reimbursement is a cost effective way to provide medical or child medical assistance to an individual, plans are required to provide, upon request, information about their benefits to State Medicaid or CHIP programs. States may begin requesting this information from plans beginning with the first plan year after the model disclosure form is issued (January 1, 2012 for calendar year plans).

  Individuals need to contact their State's Medicaid or CHIP program to determine if they are eligible for Medicaid or CHIP, and to see if their State will subsidize group health plan premiums. If they are eligible for a premium subsidy, they need to contact their plan administrator or employer to take advantage of the new special enrollment opportunity and enroll in the group health plan.

  Individuals needing assistance or with questions about the application of these provisions to their employment-based group health plan can call toll free 1-866-444-3272 (EBSA) to speak to a Benefits Advisor.

Dental Benefits

Regular, professional dental care is not only essential to good health, but it can also prevent serious and costly medical and/or dental problems. That's why the dental benefit plan encourages you and your family to see a dentist regularly. The plan places special emphasis on preventive care, but also covers many other dental services you may need.

Whether or not you elect health coverage, you can choose dental coverage for yourself and your eligible dependents. The dental plan is a preferred provider organization (PPO) with a network of participating providers. You have the option of selecting dental care in- or out-of-network each time you receive dental care, but the plan pays the greatest benefit for care received from a provider in the Ameritas network.

Dental Rewards

Dental Rewards is a valuable program that encourages good dental habits through regular dental check-ups. If you file at least one dental claim during the plan year (July 1, 2012 – June 30, 2013) and total benefits paid are less than $500, you will qualify for a reward of $250.00 ($350.00 if using a PPO dentist) increase in your annual maximum the following plan year (beginning July 1, 2013). This continues until you reach a total reward of $1,000. The Dental Reward amount earned is reduced by any amount used in any plan year.

NOTE: Orthodontia and TMJ procedures are excluded from Dental Rewards as they have their own maximum benefit.

Enrollment for Late Entrants

If you and/or your dependents do not enroll within 30 days from being eligible for insurance (this includes enrolling as a new hire, or being eligible due to a mid year qualified event) or elect to become insured again after dropping out of the dental plan, you and/or your dependents will be considered "late entrants." As an example, if an employee is hired on April 15, 2012 and elects the dental coverage, this would become effective on June 1, 2012. However, if the employee does not elect to enroll in the dental coverage as a new hire and, elects to enroll in the dental coverage during any subsequent open enrollment period they would be considered a late entrant and have the late entrant penalty (waiting period) for the first 12 months. As late entrants, your benefits will be limited to only Preventive Procedures for the first 12 months that you are covered. After 12 months, you will have access to all of the plan's benefits.

Your Dental Benefits

Basic Plan

AMERITAS DENTAL PLAN BENEFITS		
Plan Feature	PPO In-Network Dentist	Non-PPO Out-of-Network Dentist
Deductible for both Basic and Major Procedures (waived for preventive care, orthodontia and TMJ)	$50 per individual $150 per family	$50 per individual $150 per family
Maximum Benefit	$1,000	$1,000
Orthodontia & TMJ lifetime maximum (per person)	$2,000	$2,000
Preventive Procedures (exams, cleanings – 2 per year, x-rays, sealants)	Plan covers 100%	Plan covers 50%
Basic Procedures (fillings, root canals, gum disease treatment, extractions)	Plan covers 80%	Plan covers 50%
Major Procedures (initial and replacement crowns, dentures, bridges)	Plan covers 50%	Plan covers 25%
Orthodontia (to age 19) & TMJ Procedures	Plan covers 50%	Plan covers 25%

Premium Plan

Plan Feature	PPO In-Network Dentist	Non-PPO Out-of-Network Dentist
Deductible for both Basic and Major Procedures (waived for preventive care, orthodontia and TMJ)	$50 per individual $150 per family	$50 per individual $150 per family
Maximum Benefit	$1,500	$1,500
Orthodontia & TMJ lifetime maximum (per person)	$2,000	$2,000
Preventive Procedures (exams, cleanings – 2 per year, x-rays, sealants)	Plan covers 100%	Plan covers 80%
Basic Procedures (fillings, root canals, gum disease treatment, extractions)	Plan covers 80%	Plan covers 80%
Major Procedures (initial and replacement crowns, dentures, bridges)	Plan covers 50%	Plan covers 50%
Orthodontia (FOR ADULTS AND CHILDREN) & TMJ Procedures	Plan covers 50%	Plan covers 50%

Vision Care Benefits

Proper vision care is an essential part of good health. Routine eye exams can help determine the need for prescription glasses, but can also help detect symptoms of serious conditions such as glaucoma, cataracts and diabetes.

When you use the services of providers who participate in the EyeMed Vision Care network, you generally pay a small copay and the plan pays the rest. Here's how it works:

- Choose an EyeMed Vision Care participating provider at **link.ne.gov** and connect to Wellness and Benefits Resources or call **1-877-861-3459**
- Make an appointment and tell the provider you are an EyeMed Vision Care member
- Two personalized ID cards will be issued with the subscriber's name for the new enrollees only; eligible dependents can use one of the cards for identification purposes. You will need to verify with your provider that they accept your plan when scheduling an appointment. Included with your ID cards will be a listing of the EyeMed Vision Care providers near you. Present your ID card at the time of service
- Choose from thousands of convenient locations including private practitioners and leading optical retailers, such as LensCrafters, Pearle Vision, Sears Optical, Target Optical and JC Penney Optical

You have a choice of two affordable eye care plans — the Basic Option and the Premium Option. Here's how they compare:

VISION PLAN BENEFITS		
Coverage	**Basic Option**	**Premium Option**
EXAM covered in full (after $10 copay)	**every 12 months**	**every 12 months**
PRESCRIPTION GLASSES		
LENSES covered in full (after $10 copay) — Includes single vision, lined bifocal, lined trifocal lenses, and polycarbonate lenses for dependent children	**every 24 months**	**every 12 months**
OR		
CONTACT LENS allowance applied toward the cost of contacts.	**$105 every 24 months**	**$130 every 12 months**
FRAMES — Includes a frame of your choice	**every 24 months $105 allowance, 20% off balance over $105**	**every 12 months $120 allowance, 20% off balance over $120**

LEGAL DISCLAIMER: Member will receive a 20% discount on items not covered by the plan at network Providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location. Allowances are one-time use benefits; no remaining balance. Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. The plan design is offered with the EyeMed Access panel of providers. Limitations and exclusions apply. Insured plans are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri except in New York. Fidelity Security Life ºPolicy Number VC-19/VC-20 form number M-9083.

wellnessoptions Program Is Available To Those Enrolled Among ALL Health Plans

In 2009, the State of Nebraska launched a wellness program, called **wellnessoptions**, with the following goals in mind:

- to create a healthier workforce by encouraging healthy behaviors and the use of preventive care benefits;
- controlling health care costs.

The State of Nebraska is proud to offer its wellness program to all those covered employees and spouses (if applicable) enrolled in any of the four plans (Choice, Regular, High Deductible and Wellness). That's right – you can have your own personal health coach, obtain a pedometer with the Walk This Way program or attend an onsite screening – all at no cost to help you invest in your personal health!

These programs are a benefit available to you – regardless if you want to qualify for the Wellness Plan. *We encourage you and your enrolled spouse (if applicable) to take advantage of the voluntary wellness programs being offered through HealthFitness at no cost to you!* The wellness program is designed to help you evaluate and identify modifiable health risks, and provide you with guidance for living a more healthful life.

- **NEW! Cardio Log** – Based on feedback, wellness participants expressed interest in logging a greater variety of workouts. With Cardio Log, you can track a variety of sports, fitness classes, cardiovascular, strength training and flexibility workouts online.

- **NEW! NutriSum** – As a result of participants expressing interest in additional weight management programs, we are proud to offer this online weight management challenge in which participants learn strategies that have proven to be effective for weight loss and maintenance of a healthy weight.
- **Walk This Way** – Boost your activity level by wearing a free pedometer and tracking your steps online.
- **EMPOWERED Coaching™: Lifestyle Management** – Work with your own personal health coach to support and guide you in making lifestyle changes.
- **EMPOWERED Coaching™: Condition Management –** Individuals with a chronic condition can work with a coach to help manage their health, feel better and enjoy the best quality of life.
- **Onsite Biometric Screenings** – Get a free blood pressure, cholesterol, triglyceride and glucose screening.
- **Online Health Assessment** – Results are confidentially provided in a comprehensive personal report.
- **Online Resources** – Healthy News, Health Resources, My Health Trackers, Family Health Guide and Cool Tools are examples of some valuable online resources.

The Cost of Unhealthy Behaviors

Rising health care costs are a concern for all of us as individuals and for the State of Nebraska. A recent study (Mercer Health & Benefits) expected an average increase of 9.8% nationally in health care costs for 2012. Like all companies that provide health coverage for employees, the State of Nebraska faces health care costs that represent many millions of dollars of expense every year. Because the State of Nebraska pays for 79% of the costs associated with health care, the State believes in providing resources to address modifiable health risks to control health care costs.

The evidence is all around us – with the skyrocketing rate of obesity and the growing prevalence of diabetes, coronary heart disease, high blood pressure, and many other conditions that can all be addressed by the choices we make – or fail to make – each and every day. Did you know that obesity is now the #2 cause of preventable death in the United States? When comparing obesity rates (BMI > 30) of the State of Nebraska aggregate health assessment data of 37% to National (27%) and state-wide (28%) prevalence rates, the comparison is extremely concerning. This is in addition to another 33% State of Nebraska participants who are classified as 'overweight' (BMI 25-29.9). As a result, this data shows that 71% of our State of Nebraska population is either 'overweight' or 'obese'.

Over the past 15 years, research has documented that up to 70 percent of total health costs can be preventable through lifestyle choices including healthy eating, managing a healthy weight, engaging in regular physical activity, no tobacco use and managing stress.

Life Saving and Cost Saving

Not to mention the impact related to a greater chance of more favorable health outcomes, the average State of Nebraska healthcare cost was found to be 93 times less for treating an early stage of colorectal cancer versus treating a late form of colorectal cancer.

Good News That Benefits Us All

There is good news at the State of Nebraska and it is this: When the national health care costs average increase is approximately 10%, the State's experience is far less than the national trend.

The savings is primarily coming from reduced health care utilization and reduced prescription drug utilization as a result of lifestyle improvements combined with an increase in prevention and early detection screenings.

The Benefits of Prevention and Early Detection are Countless!

Preventive screenings have increased the past two years resulting in a significant number of individuals detecting conditions in an early stage including:

- Colorectal Cancer:
  - 457 cases of benign polyps were detected
  - 93x less costly to treat when caught in the early stage
- Breast Cancer:
  - 4 new cases of early stage cancer was detected
  - 3.5x less costly to treat when caught in the early stage
- Cervical Cancer:
  - 53 pre-cancerous lesions were detected
  - 67x less costly to treat when caught in the early stage
- Other conditions newly diagnosed:
  - 1,169 new high cholesterol cases diagnosed
  - 1,323 new high blood pressure cases diagnosed

Decreasing Premiums

Wellness Plan premiums have decreased 3.3% compared to last year!

Strong Participation Results in Health Improvements

After three years of providing the State of Nebraska **wellnessoptions** program, much has been accomplished in terms of improving lifestyles, reducing risk factors and increasing the participation in early detection screenings. At the end of December 2011, over 5,800 employees and 2,500 spouses have enrolled in a wellness program (approximately 42% of the eligible employee population). Participation in the wellness program has increased 10% as compared to last year.

Over 5,000 participants enrolled in the Walk This Way program – literally achieving millions of steps. Over 1,700 have logged over 1 million steps and several logged over 6 million steps. We even have our first participant logging over 10 million steps!

In addition, over 4,000 are receiving guidance and support with their participation in a coaching program, including those with a chronic health condition.

Aggregate results among wellness program participants have shown a reduction in the average number of individual risk factors. Associated health improvement results include increased levels of physical activity and consumption of fruits and vegetables, in addition to decreased prevalence of tobacco use and stress. In fact, 130 participants have now quit smoking as a result of the wellness program.

"Our success in leading healthy lifestyles is a great example of what is possible when you make a commitment to invest in your personal health."

-Governor Heineman

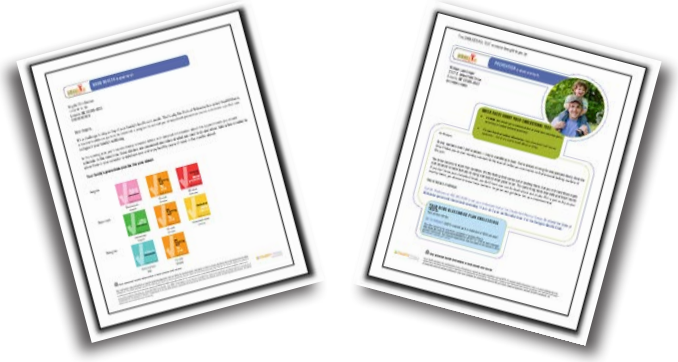
Early Detection Efforts Are Paying Off and Saving Lives!

Personalized reminders of preventive screenings are mailed to homes among those enrolled in any of the four State health plans to increase the awareness and use of preventive and early detection screenings.

Before the launch of this initiative, only 33% of employees were current with their recommended preventive screenings (based on national recommendations). Seventy percent are now current with their recommended preventive screenings! The screenings have resulted in 'catching' many cases of early stage, and even late stage cancers.

Specifically over the past two years, 514 new cases of early stage cancer were detected and 26 new cases were diagnosed with a late stage of cancer. Not to mention the impact related to more favorable health outcomes, but significant cost savings are also associated with identifying these cases in an early stage. In fact, the average State of Nebraska health care cost was found to be 93 times less for treating an early stage of colorectal cancer versus treating a late form of colorectal cancer.

Other conditions newly diagnosed from onsite biometric screenings include over 1,100 new high cholesterol cases, and 1,300 new high blood pressure cases. The benefits of prevention and early detection are numerous!



wellnessoptions Earns Two National Wellness Awards

The State of Nebraska has been awarded the Gold Well Workplace Award presented by the Wellness Council of America for its wellness program for state employees. Nebraska is one of only two states to win the award. "I am very pleased with the success of our wellness program and I am even more pleased that state employees are embracing this program," Gov. Dave Heineman said in reflecting on the early progress of the Wellness Program.

The State of Nebraska was awarded the 2011 Innovations Award from The Council of State Governments for its breakthrough program within the first three years of operation. The Innovation Award is given for the development and implementation of exemplary programs, so the successful ideas and experiences can be applied to other states. The award recognizes newness, creativity, effectiveness, transferability and significance.

Thanks Wellness Champions!

The Wellness & Benefits Department has utilized a team of Wellness Champions from several different agencies and state-wide locations to provide constructive feedback and help with promoting wellness. Wellness Champions encourage healthy behaviors in hopes to positively impact the quality of life for the State of Nebraska workforce while controlling health care costs. They are instrumental in providing their thoughts with several Wellness Plan design enhancements.

State Employees Earn Wellness Wall of Fame Recognition

Periodically, we learn about success stories from employees participating in the **wellnessoptions** program with some pretty amazing lifestyle changes resulting in significant health improvements. For many, it is a life changing experience – almost a second outlook on life. In hopes of being motivating to others, stories such as this receive recognition by being displayed on the Wellness Wall of Fame, which includes obtaining a picture with the Governor in addition to receiving a personal letter from the Governor.

For more information on all wellnessoptions programs, Wellness Plan qualification requirements and more, visit link.ne.gov and connect to Wellness and Benefits Resources or call Health Fitness at 1-866-956-4285.

Is the Wellness Plan Right for Me?

- Are you willing to **invest** in your personal health?
- Are you willing to **take the time** to participate in various wellness programs?
- Are you willing to take the time to **learn the 3 STEPS and deadlines**?
- Is **prevention and early detection** important to you?
- Do you have a vested interest in a **shared responsibility to control health care costs**?
- Are **low premium costs** important to you?

IMPORTANT: Qualifying for the Wellness Plan is purely based on participation and completion of specific wellness programs and NOT based on personal results, health risks or conditions.

Qualifying For the Wellness Plan

Key features of the Wellness Plan include low premiums and high quality coverage related to preventive screenings. Participants must complete 3 STEPS on an annual basis in order to qualify for the Wellness Plan for the 2013-14 plan year. At the beginning of each annual cycle, participants will choose and enroll in a wellness program (STEP 1), and then finish each annual cycle by completing a biometric screening (STEP 2) and Health Assessment (STEP 3). IMPORTANT: Qualifying for the Wellness Plan is purely based on participation and completion of specific wellness programs and NOT based on personal results, conditions or health risks.

Those individuals who meet the Wellness Plan criteria will have the option of electing or remaining in the Wellness Plan. Those who did not complete the criteria will not qualify for the Wellness Plan but will have the option to enroll in the High Deductible Plan, Regular Plan, or Choice Plan.

IMPORTANT: If you enroll in the Wellness Plan during Open Enrollment and fail to meet the THREE STEP criteria, you will automatically be defaulted to the Regular Plan at the appropriate tier, based on the effective date.

Annual Cycle for Qualifying into Enrollment for the Wellness Plan (3 Steps)

Steps	Wellness Criteria	Program	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Step 1	Enroll in Wellness Program	NutriSum	Step 1: Wellness Program Enrollment Period									Finishing completing program						Qualify for Wellness
		Cardio Log																
		EMPOWERED Coaching																
		Walk This Way																
		Condition Management																
Step 2	Biometric Screening Options	Onsite Screening													Step 2			
		Alternative Means Form																
		Home Kit Screening																
Step 3	Health Assessment	On-Line													Step 3			

Check Your Checkmark!

The **wellnessoptions** website now has an easy to read Wellness Plan Checklist to help you track the completion of the three necessary steps to qualify for the Wellness Plan. After you log-in with your unique user name and password, please review your own Wellness Plan Checklist. The Completed Criteria Activity tab will provide you further detail regarding your completed qualifying activities. The Checklist will update itself on June 1, 2012 to reflect 2013-14 Wellness Plan qualification criteria. Use this tool to guide you towards qualifying for the Wellness Plan!

Completed Criteria Activity

For 2013-14 Plan Year

(If checked ✓, step is completed)

- ❍ **Step 1:** Met criteria for ONE of the following Wellness Programs: (≥means greater than or equal to)
  - ❍ Coaching – ≥ 3 calls (EMPOWERED or Condition Mgt.)
  - ❍ NutriSum – ≥ 300 NutriSum points AND ≥ 1,200 exercise minutes
  - ❍ Walk This Way – ≥ 700,000 steps
  - ❍ Cardio Logs – ≥ 40 workouts (≥ 30 minutes per day)
- ❍ **Step 2:** 2013 Biometric Screenings
- ❍ **Step 3:** 2013 Health Assessment
- ❍ **My three 2013-14 Wellness Plan steps are complete!**

Learn more about the 2013-14 Wellness Plan qualifications.

Wellness Program Detail

STEP 1. Enroll and begin participation in your choice of at least one Wellness Program (beginning April 2, 2012)

To qualify for enrollment into the Wellness Plan for the next plan year (2013-2014), enroll in your choice of at least one of the following wellness programs any time before December 28, 2012 and complete it before March 29, 2013:

NutriSum

Learn successful strategies for weight loss and earn points for recording healthy daily activities such as: eating breakfast, drinking 5 or more glasses of water, avoiding eating after dinner and more. This program is located within the 'Featured Programs' section on the website (left toolbar).

Wellness Plan criteria: Participants must enroll before December 28, 2012 and earn a minimum of 300 NutriSum points AND complete a minimum of 1,200 total exercise minutes by March 29, 2013.

Cardio Log

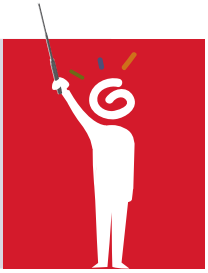
One of the best ways to maintain or improve your health is to engage in physical activity each day. Based on feedback, you can now record a greater variety of physical activities whether it is sports, fitness classes, cardiovascular, strength training, flexibility workouts and more, online.

Wellness Plan criteria: Log a minimum of 40 completed workouts online from April 2, 2012 through March 29, 2013 within Cardio Log. You must begin logging your workouts before December 28, 2012. A qualifying workout must be a minimum of 30 minutes per day. *(Qualifying workout examples include: one 30-minute entry per day OR two 15-minutes entries per day OR three 10-minute entries per day.)*

For more information on all wellnessoptions programs, Wellness Plan qualification requirements and more, visit link.ne.gov and connect to Wellness and Benefits Resources or call Health Fitness at 1-866-956-4285.

For website log-in support, call

1-866-956-4285 option 1.



Walk This Way

Whether you are currently inactive or active, boost your activity level by wearing a pedometer and tracking your steps online.

Wellness Plan criteria: New and previous Walk This Way participants must enroll before December 28, 2012 and log a minimum of 700,000 steps online before March 29, 2013.

EMPOWERED Coaching™: Lifestyle Management

Work with a coach to support and guide you in making lifestyle changes by selecting among 13 different focus areas related to physical activity, healthy eating, stress management and smoking cessation. Participants can enroll at the time of your Health Advisor call OR by calling 1-866-956-4285 Option 2 ('My Coach' left toolbar selection).

Wellness Plan criteria: New and previous EMPOWERED participants must enroll before December 28, 2012 and complete 3 or more phone calls with your health coach before March 29, 2013.

NOTE: You may use message boards for correspondence, but you must talk with your coach 3 or more times via telephone to qualify for the Wellness Plan.

EMPOWERED Coaching™: Condition Management

Individuals with a chronic condition (Heart or Respiratory Conditions, Diabetes, Depression, Back Pain) can work with a coach, in conjunction with your physician, to help manage your health, feel better and enjoy the best quality of life.

Only new Condition Management participants need to enroll before December 28, 2012; current participants can continue calls and do not need to re-enroll.

NOTE: The EMPOWERED Coaching program now includes Condition Management and Lifestyle Management services together in one coaching program.

Wellness Plan criteria: Enroll before December 28, 2012 by calling 1-866-956-4285 Option 2 and complete 3 or more coaching phone calls before March 29, 2013.

For more information on all wellnessoptions programs, Wellness Plan qualification requirements and more, visit link.ne.gov and connect to Wellness and Benefits Resources or call Health Fitness at 1-866-956-4285.

The Annual "3-STEP" Cycle Starts!

Begin Qualifying for the 2013-14 Wellness Plan

Participants must complete 3 STEPS on an annual basis in order to qualify for the 2013-14 plan year. At the beginning of each annual cycle, participants will choose and enroll in a wellness program (STEP 1), and then finish each annual cycle by completing a biometric screening option (STEP 2) and the online Insight Health Assessment (STEP 3).

Both the enrolled employee and enrolled spouse (if applicable) must complete the following 3 STEPS during the current plan year in order to qualify for the following Wellness Plan (2013-14 plan year).

STEP 1. This Spring – Wellness Program

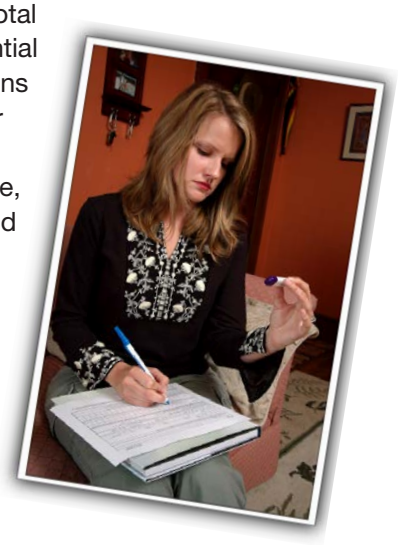
- Enroll in your choice of at least one Wellness Program from April 2, 2012 thru December 28, 2012
- Complete your choice of one wellness program by March 29, 2013

STEP 2. Next Spring (April 1 – May 31, 2013) – Complete your annual Biometric Screening

STEP 3. Next Spring (April 1 – May 31, 2013) – Complete your annual online Insight Health Assessment

STEP 2. Complete one annual Biometric Screening option (Starting April 1, 2013)

Starting April 1, 2013, a total of three different confidential biometric screening options are available to learn your cholesterol levels, HDL, LDL, triglycerides, glucose, blood pressure, height and weight. The three options include:



- **Onsite screenings** will be offered at approximately 30 State of Nebraska locations
- **Home kits** can be requested to obtain a finger-stick blood draw kit mailed to your home
- An **Alternative Means Screening (AMS)** form will be available to submit recent biometric screening results (height, weight, blood pressure, total cholesterol, glucose) from appointments scheduled with your personal physician.

STEP 3. Complete your annual online Insight Health Assessment (April 1 – May 31, 2013)

- Complete the annual online Insight Health Assessment, which is located on the Health Home page within the 'Complete your HEALTH ASSESSMENT' section, then select 'Click here to complete your Health Assessment'
- The online Insight Health Assessment includes 82 confidential questions regarding your lifestyle choices. Select the 'Save/Finish' button at the end

IMPORTANT: Failure to complete the online Health Assessment by the deadline for those that have recently elected the Wellness Plan will result in defaulting to the Regular Plan at the appropriate tier, based on the effective date.

Confidentiality is a Top Priority

Privacy of personal information is a top priority with the Wellness Program. HealthFitness maintains the confidentiality of all personal health information in accordance with federal regulations. That means your personal health information, which is obtained by HealthFitness, will not be released to the State of Nebraska.

No Penalties for Poor Health

The Wellness Plan qualification criteria is based on active participation and completion of specific wellness programs, and is not based on your individual health factors, health assessment results or biometric screening results. That means you will not be penalized for having or reporting poor health behaviors, lifestyle risks or conditions.

Your personal health information will not be held against you.

Federal regulations prohibit a group health plan from discriminating among individuals based on their health status. This means that group health plans cannot charge individuals different premiums or impose different costs (i.e., through deductibles or copays) based on the absence or existence of a health factor. Because the State of Nebraska does not condition eligibility for the Wellness Plan upon a participant's ability to meet a health standard, the program meets the nondiscrimination requirements under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Congratulations!!!

Those who are taking the time to invest in their personal health by qualifying for the Wellness Plan will be rewarded with lower premium costs.

Give Yourself A Raise!
Wellness Plan Premium Savings

The State of Nebraska offers employees four self-funded health plans to choose from for providing health care benefits for you and your family. This means that both you and State of Nebraska share the costs associated with all medical and prescription costs. Employees contribute to health care costs by paying premiums, which accounts for 21% of health care costs. The State of Nebraska pays the remaining 79% of your health care costs.

As the below charts depict, by simply switching from a higher cost plan to a lower cost plan you can save hundreds, or even thousands, of dollars a year!

Prior to the initiation of the Wellness Program, the State experienced double-digit health care cost increases each year. Last year, the State's overall cost trend was less than a 1% increase across all State of Nebraska health plans.

Those who are taking the time to invest in their personal health by qualifying for the Wellness Plan will be rewarded with lower premiums and more money in their paychecks! **CONGRATULATIONS!**

COVERAGE	CHOICE PLAN (Employee's Annual Premium	REGULAR PLAN (Employee's Annual Premium	ANNUAL EMPLOYEE SAVINGS BY SWITCHING FROM THE CHOICE PLAN TO THE REGULAR PLAN
Single	$1,566.24	$1,258.08	$308.16
Two Party	$4,156.80	$3,339.12	$817.68
Four Party	$3,216.96	$2,584.08	$632.88
Family	$5,559.60	$4,465.92	$1,093.68

For more information on all wellnessoptions programs, Wellness Plan qualification requirements and more, visit link.ne.gov and connect to Wellness and Benefits Resources or call Health Fitness at 1-866-956-4285.

Annual Governor's Wellness Award Banquet

The Governor of Nebraska has been an avid supporter of wellness initiatives for the State of Nebraska. Each year, the Governor recognizes individuals and agencies for going above and beyond in promoting and establishing a healthy lifestyle. At the 2011 Governor's Wellness Award Banquet, 23 Wall of Fame recipients were recognized, in addition to 23 Wellness Champions. The Wellness Champion Award recipients were Paul Norrid (Corrections), Dave Hattan, (Department of Administrative Services), and Barbara Peterson (Insurance). Each year, the Governor's Wellness Champion award recipients are selected for their involvement, actions and efforts that:

- Contribute towards achieving wellness goals
- Promote wellness
- Demonstrate a positive attitude that inspires others.

The **Department of Environmental Quality** was the recipient of the Governor's Agency Wellness Award, achieving 52% wellness participation with a 9% increase over the previous year, and experiencing significant health improvements based on aggregate health assessment and biometric comparative data. Each year, the Governor's Agency Wellness Award goes to the agency that has the highest objective score among the following three factors:

- Current Wellness Program Participation: percentage participation among all those who are eligible to participate within each Agency
- Wellness Program Participation Growth: percentage participation change from the current year to the previous year
- Health Improvements: based on Agency aggregate health assessment and biometric data comparing the average number of risk factors from the current year to the previous year.

Governor's Wellness Champion Award Winner: Dave Hattan, Department of Administrative Services

Governor's Agency Wellness Award Winner: Department of Environmental Quality

Counseling Services - Your EAP

The Employee Assistance Program (EAP), provided through Best Care, offers free, confidential counseling and referral services to help you and your family deal with issues that may be affecting your job performance or personal well-being. Counselors are trained to help with such issues as:

- marital or relationship concerns
- family or parent challenges
- stress
- substance abuse
- grief / depression

Not all State agencies have elected to provide EAP coverage for their employees. Please contact your agency Human Resource office to determine whether your agency is participating in the EAP provided through Best Care.

When you contact the EAP, you'll speak with a specialist who can help identify the issue, determine the most suitable type of assistance and work with you on a course of action. The EAP is available 24 hours a day, seven days a week. All consultations and counseling are completely confidential.

Contact the EAP at **800-666-8606** or **402-354-8000** to arrange for a private and confidential appointment.

Why is Asking for Help So Difficult?

You may be afraid of looking weak, needy or incompetent; however, stalling can let a situation grow from a problem into a crisis. Asking for assistance during a personal or professional challenge shows good judgment. Best Care EAP is available to support you through difficult situations.

"When my whole world came crashing down around me, I didn't want my career to fall apart also. Best Care EAP helped to provide stability when I desperately needed it."

"My Best Care Counselor was great. The first step, calling was the hardest, they made the rest easy."

"The Best Care team makes the process seamless. It is encouraging to know that I can schedule appointments soon after the need arises rather than delaying the process. Thank you!"

"I believe the quickness with which I was able to access counseling, and the quality of the service, enabled me to handle a very difficult situation in the best possible manner. The problem didn't go away but my perspective improved to where I could start dealing with it."

"Best Care helped me to see beyond the issue on the surface, and how my decisions can influence the outcome."

"I appreciate this benefit of my job immensely. Employees who do not use this resource are missing out on a great opportunity for support and encouragement."

Time to Enroll

Open Enrollment

BEGINS:
Friday, May 25, 2012
at 8:00 a.m. C.D.T.

ENDS:
Friday, June 8, 2012
at 5:00 p.m. C.D.T.

Before you enroll, consider this checklist of items:

- ✔ Read this guide
- ✔ Keep in mind that the elections you make are in effect from July 1, 2012 through June 30, 2013
- ✔ Become familiar with your benefit options
- ✔ Talk to your family and share benefit decisions
- ✔ Gather the Social Security numbers of all of your enrolled dependents
- ✔ Get questions answered through vendor telephone numbers and websites (see back cover)

Notes:

Contact Information

Here are resources to contact if you have questions about your coverage options.

FOR MORE INFORMATION ABOUT…	CALL …	OR GO TO…
Health Plans UnitedHealthcare	1-877-263-0911	link.ne.gov and connect to Wellness and Benefits Resources
Prescription Drug Plan and Speciality Pharmacy OptumRx™	1-877-263-0911	
Dental Plan Ameritas	1-800-487-5553	
Vision Plan EyeMed Vision Care	1-877-861-3459	
EAP Best Care	1-800-666-8606	
Nebraska State Employee Wellness and Benefits	402-471-4443 (in Lincoln) 1-877-721-2228 (outside Lincoln	

NEBRASKA
AdministrativeServices

State Employee Wellness and Benefits • 301 Centennial Mall South, Lower Level • Lincoln NE 68509